

KEVIN J. DAILY, D.D.S., INC.

PATIENT REGISTRATION

ID: _____ Chart ID: _____

First Name: _____ Last Name: _____ Middle Initial _____

Patient Is: Policy Holder Preferred Name: _____
 Responsible Party

Responsible Party (if someone other than the patient) _____

First Name: _____ Last Name _____ Middle Initial _____

Address: _____ Address 2: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cell: _____

Birth Date: _____ Soc. Security: _____ Driver's Lic.: _____

Responsible Party is also a Policy Holder for Patient Primary Insurance Policy Holder Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cell: _____

Sex: Male Female Marital Status: Married Single Divorced Separated Widowed

Birth Date: _____ Age: _____ Soc. Security: _____ Driver's Lic.: _____

Section 2

Employment Status: Full Time Part Time Retired

Student Status: Full Time Part Time

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

Section 3

Additional Comments:

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other

Insured Soc. Sec.: _____ Insured Birth Date: _____

Employer: _____

Insurance Company: _____

Address: _____

Address: _____

Address 2: _____

Address 2: _____

City, State, Zip: _____

City, State, Zip: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other

Insured Soc. Sec.: _____ Insured Birth Date: _____

Employer: _____

Insurance Company: _____

Address: _____

Address: _____

Address 2: _____

Address 2: _____

City, State, Zip: _____

City, State, Zip: _____

Patient Name _____
 Patient Account No. _____

Medical Alert _____

DENTAL HISTORY

*Welcome! So that we may provide you with the best possible care
 please complete both sides of this medical/dental history form.
 All information is completely confidential.*

What is the reason for your visit today? _____

Date of Last Dental Visit _____ Last Dental Cleaning _____ Last Full Mouth X-rays _____

What was done at your last dental visit? _____

Previous Dentist's Name _____

Address _____ State _____ Zip _____

Telephone _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids do you use? (Interplak, toothpick, etc.) _____

Do you have any dental problems now? Yes No

If yes, please describe: _____

Are any of your teeth sensitive to:

Hot or Cold? Yes No

Sweets? Yes No

Biting or Chewing? Yes No

Have you noticed any mouth odors or bad tastes? Yes No

Do you frequently get cold sores,
 blisters or any other oral lesions? Yes No

Do your gums bleed or hurt Yes No

Have your parents experienced gum disease or tooth loss? Yes No

Have you noticed any loose teeth or change in your bite? Yes No

Does food tend to become caught between your teeth? Yes No
 If yes, where? _____

Do You:

Clench or grind your teeth while awake or asleep? Yes No

Bite your lips or cheeks regularly? Yes No

Hold foreign objects with your teeth?
 (pencils, pipe, pins, nails, fingernails) Yes No

Mouth breath while awake or asleep? Yes No

Have tired jaws, especially in the morning? Yes No

Smoke/chew tobacco? Yes No

Snore, have trouble waking in the
 morning, or feel sleepy during the day? Yes No

Have you ever had:

Orthodontic Treatment? Yes No

Oral surgery? Yes No

Periodontal treatment? Yes No

Your teeth ground or the bite adjusted? Yes No

A bite plate or mouth guard? Yes No

A serious injury to the mouth or head? Yes No

If so, please describe, including cause: _____

Have you experienced:

Clicking or popping of the jaw? Yes No

Pain? (joint, ear, side of face) Yes No

Difficulty in chewing on either side of the mouth? Yes No

Headaches, neck aches, or shoulder aches? Yes No

Sore muscles (neck, shoulders)? Yes No

Are you happy with you teeth's appearance? Yes No

Would you like to keep all of your teeth all of your life? Yes No

Do you feel nervous about having dental treatment? Yes No

If so, what is you biggest concern? _____

Have you had an upsetting dental experience? Yes No

If so, please describe: _____

Is there anything else about having dental treatment that you would like us to know? Yes No

If yes, please describe _____

Consent For Treatment

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to a thorough diagnosis of (Name of patient) _____ 's dental needs
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistants as required to provide proper care.
3. I agree to the use of anesthetic, sedative and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks, I understand that I can ask for a complete recital of any possible complications.
4. I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice full outlining the protection of my personal health information is available.
5. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not recieved by agreed upon dates, I understand that a 1^{1/2}% late charge (18% APR) may be added to my account.

Patient's Signature _____ Date _____

Patient/Responsible Party's Signature _____ Relationship to Patient _____